

- The persons to whom compensation shall be paid are:
- (a) The widow or widower of the deceased employee at the time of his death.
 - (b) The child or children of the deceased employee at the time of his death.
 - (c) The unmarried children under 18, and those over 18 who are incapable of self-support.
 - (d) Parents of the deceased employee for support.
 - (e) Unmarried brothers, sisters, or fraternal children under 18 years of age, and those over 18 who are incapable of self-support, and who were wholly or partially dependent upon the deceased employee.
 - (f) Grandparents wholly or partially dependent upon the deceased employee.

Under the law, the term "child" includes stepchildren, adopted children, and posthumous children, but does not include married children. The terms "brother" and "sister" include stepbrothers and stepsisters, half brothers and half sisters, and others and sisters by adoption, but do not include married brothers or sisters. All of the above terms and the term "grandchild" include only persons who at the time of the death of the deceased employee are under 18 years of age or over that age and incapable of self-support. The term "parent" includes step-parents and parents by adoption. The term "widow" includes the deceased's wife living with or dependent for support upon him at the time of his death. The term "widower" includes the deceased's husband dependent for support upon her at the time of her death. The terms "adopted" and "adoption" used in this law include only legal adoption prior to the time of the injury.

The claim should be signed by the person making the claim or his duly authorized representative. There should be given names and addresses of all persons who may be entitled to compensation on account of death, together with the address of the person making the claim, which should be sworn to by the person entitled to compensation, or by the person authorized to do so on his behalf.

Oaths of claimants residing in foreign countries should be made before a United States consular officer or secretary of legation. If before a local official, a certificate of such United States consular official or secretary of legation showing the authority of local official to administer oaths should be annexed.

A certified copy of the death certificate should accompany this claim. If, for any reason, it cannot be secured, give full notation at the bottom of this sheet.

If the relationship to the decedent of any person entitled to claim compensation is that of adoption, a certified copy of the order of adoption should accompany this claim.

Itemized bill in duplicate covering the medical and burial expenses should be submitted with the claim.

Full name of deceased employee Frank Rudolph Olson
Age 43 3. Sex M 4. Occupation Supervisory Biochemist
Was deceased able to speak English? Yes 6. If not, what language? _____
Time of injury: (a) November; (b) 23 (c) 1953 (d) 2:30 a.m.
Place where injury occurred Hotel Statler, New York City, New York
Nature and extent of injury Multiple fractures, shocks, and hemorrhage resulting in death.

Date of death 25 November 1953
Place where death occurred Statler Hotel, New York City, New York
Rate of pay of deceased employee at time of injury which resulted in death, \$ 2200.00 per annum
and subsistence valued at \$ _____ per _____

Relationship to the deceased of the person claiming to be entitled to compensation wife
Did deceased leave any other relatives entitled to compensation? No If so, give names, addresses, ages, and relationship below.

(See instructions at top of form for names of persons entitled to compensation)

Name	Address	Age	Relationship
Eric Wicks Olson	R.F.D.#5, Frederick, Md.	9	Son
Elsa Wicks Olson	R.F.D.#5, Frederick, Md.	7	Daughter
Els Wicks Olson	R.F.D.#5, Frederick, Md.	5	Son

I HEREBY CERTIFY that each and every statement set forth above is true to the best of my knowledge and belief.

Name: Alice Wicks Olson
Address: R.F.D. #5
Frederick Maryland
(City) (State)

CLAIMANT'S CERTIFICATE

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Name of deceased employee _____
 Social Security number of employee _____
 Date of employee's death _____, 19____
 Place and cause of death _____
 Contributory cause of death _____
 History of injury given in this case? _____ If so, state it briefly _____
 In your opinion, was the death of the employee due to such injury? _____
 Remarks: _____

I HEREBY CERTIFY that the answers to the above questions are true to the best of my knowledge and belief.

(Signature of certifying physician)

Address: _____
 (Street and number)

(City)

(State)

This certificate, _____, 19____

It is important that above certificate be furnished, but if for any cause it cannot be secured, give full explanation below and submit such other proof of death as may be obtainable.

CERTIFICATE OF OFFICIAL SUPERIOR

If report of death on Form No. C.A. 3 has not been forwarded to the Bureau, such report should be made and accompany this claim for compensation.

I HEREBY CERTIFY that the person on account of whose death the foregoing claim is made was employed by the United States Government when injured and official report of death was made on 28 November 1955
 (Date)

If the certifying physician has a question which after the certifying physician stated in the official report of death, or if the official superior disagrees with any of the statements made on the certificate, it is requested that a full explanation be made below.

Remarks: _____

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1. Department Army
(War, Navy, etc.)

3. Place of employment Camp Detachment
(Army, Navy, etc.)

4. Full name of injured employee _____

5. Time of injury _____, 19____
(Date) (Day of week) (Hour, a. m. or p. m.)

6. Time employee stopped work _____, 19____
(Date) (Day of week) (Hour, a. m. or p. m.)

7. Time employee's pay stopped _____, 19____
(Date) (Day of week) (Hour, a. m. or p. m.)

8. First day employee was able to resume work _____, 19____
(Date) (Day of week) (Hour, a. m. or p. m.)

9. Did employee return to the same work and at same rate of pay after termination of disability?
If so, when? _____ If not, state character of work performed upon return to
duty and rate paid employee for such work _____

2. Bureau or office Medical Service
(Hospital, Dispensary, etc.)

10. Actual time disabled (including Sundays and holidays) _____ days.

11. Number of days for which employee would have received pay had he not been disabled _____ days.

12. If employee was receiving subsistence as part of his wages, was such subsistence furnished during entire period of disability? _____ If not, give dates on which subsistence was not furnished _____

13. Has employee been paid for any portion of above absence on account of—
(a) Annual leave? _____ (Give exact dates)
(b) Sick leave? _____ (Give exact dates)
(c) Any other reason _____

4. Nature of injury _____

5. Remarks _____

[The following information is to be furnished only in case of death resulting from an injury sustained while in the performance of duty. If death results immediately, or if no report of injury has previously been submitted, such report, on Form C. A. 2, should be forwarded herewith.]

REPORT OF DEATH

1. Full name of deceased employee Frank R. Olson

2. Time of death 23 November, 1953 Saturday 2:30 p.m.
(Date) (Day of week) (Hour, a. m. or p. m.)

3. Time employee's pay stopped 24 November, 1953 Sunday 1:30 p.m.
(Date) (Day of week) (Hour, a. m. or p. m.)

4. Place of death Station Hotel New York City, New York
(Name of hospital, establishment, etc.) (City, or town, and State)

5. Immediate cause of death Multiple fractures, shock, and hemorrhage resulting from fall from tenth floor of hotel

6. Widow of deceased employee Alice M. Olson R. F. Dwyer Frederick Maryland
(Give full name.) (Address)

7. Children of deceased employee under 18 years of age, or those over 18 who are incapable of self-support:

Name.	Age.
<u>Erica Wickes Olson</u>	<u>8</u>
<u>Lisa Wickes Olson</u>	<u>7</u>
<u>Wills Wickes Olson</u>	<u>5</u>

8. Names, relationship, and addresses of all other persons known to be dependent, in any degree, upon decedent at time of death:

Name.	Relationship.	Address.
<u>None</u>		

Place of employment

The injured employee

be injury

1. Department Police 2. Bureau Tactical Group

3. Place of employment Washington, D.C.

4. Reporting office 30 Division of Investigation

5. Name of superintendent or foreman in charge when injury occurred Col. V. L. Tamm

6. Name of injured employee Frank Adolph Olson 7. Age 33 8. Sex M 9. Race W

10. Home address P.F.D. 25 (Give full name in full) Frederick Maryland

11. Occupation and division Supervisor, Maintenance, SO Division Was employee doing his regular work? Yes If not, what work?

12. Total length of service with the Government as a civilian? 8 1/2 years

13. How long at present work in this establishment? 8 1/2 years

14. Dates of other injuries 19 November 1953 is date of injury causing death on 23 Nov.

15. Rate of pay on date of injury, \$ 9300.00 per annum { and subsistence valued at \$ _____ per _____ and quarters valued at \$ _____ per _____

16. Employee begins work at 7:45 a.m. m. 17. Regular day work ends 4:30 p.m. m.

18. Hours worked per day 8 19. Days per week 5

20. Place where injury occurred (death) Statler Hotel, New York City, N. Y.

21. Date of injury (death) 23 November, 1953; day of week Saturday; hour of day 2:30 a.m.

22. Date employee stopped work 27 November, 1953; day of week Friday; hour of day 4:00 p.m.

23. Date employee's pay stopped 27 November, 1953; day of week Friday; hour of day 4:30 p.m.

24. Has employee returned to work? No (Give exact hour)

25. Will employee receive pay for any portion of above absence on account of:

(a) Annual leave No (Give exact date)

(b) Sick leave No (Give exact date)

(c) Any other reason No (Give exact date)

26. Describe in full how injury occurred Jump or fall from top floor of hotel

27. State part of body injured and nature and extent of injury Multiple fractures, shock, and hemorrhage resulting in death

28. Did injury cause loss of any member or part of member? No If so, describe exactly

29. Was employee injured while in performance of duty? Yes If not, give detailed statement

Death resulted from circumstances arising out of his official duties

30. Was injury caused by:

(a) Willful misconduct of the employee? (b) Intention of employee to bring about injury or death of himself or another? (c) Employee's intention

(If any answers to these questions are affirmative, the reporting officer must attach an additional statement giving the reasons for his conclusion.)

31. Was written notice of injury given within 48 hours? Yes If not, did immediate superior have actual knowledge of injury? (Answer to question 3, Form C. A. 1, must be complete if notice was not given within 48 hours)

32. Names and addresses of witnesses to injury Mr. Robert V. Johnson 1855 New Hampshire N.W. Washington, D.C.

33. Was injury caused by a third party other than a Government employee agency? No If so, has employee been instructed in procedure under the Bureau's regulations?

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NOTICE—Read carefully instructions on the back before executing this affidavit.

Frederick, Maryland
(State or Territory where executed)

SS:

I, Alice Smith Wicks Olson, being duly sworn, on oath say that I am resident

RD 75, city of Frederick, county of Frederick

State of Maryland; that on the 25th day of November, 1951

Husband Frank Rudolph Olson had personal domicile in and was a resident

city of Frederick, county of Frederick, and State of Maryland

on said day died intestate; that burial expenses amounting to Six-hundred and ninety-three dollars

and fifty cents (93.50) were incurred, as per original itemized bills herewith; that the amount of None

dollars (\$) has been paid on such burial expenses

from funds belonging to

that there is a balance of Six-hundred and ninety-three dollars and fifty cents (\$693.50)

being unpaid.

(Here the affiant must state specific facts as indicated by instructions on back of this form).

Surviving dependents are:

Widow - Alice Smith Wicks Olson

Son - Eric Wicks Olson

Son - Willa Wicks Olson

Daughters - Lisa Wicks Olson

ed served in the military or naval forces of the United States as follows:

March 20, 1942 - April 13, 1944, inclusive. Chemical Warfare Service

(If none, so state; otherwise give organization, period of service, and Army serial number, if known)

Will Not be made to the Veterans' Administration for burial expenses; that at the time of

case compensation was due said decedent from the Bureau of Employees' Compensation, and

there has been no administration, and if any amounts payable under the Employees' Compensation Act be paid,

administration will be required.

(Signature must be in ink or indelible pencil. A signature by more than one person must be witnessed by two persons)

Alice Smith Wicks Olson

WAX to by said before me, and subscribed in my

this day, at my office in said city. And I certify that said affiant is personally well known to me to be the